STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE & ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

Instate and Out-Of-State Individual Provider In Private Practice or Provider Joining A Group

In response to your interest in participating in the Tennessee TennCare/Medicaid Program, we are providing the necessary documents for enrollment.

Tennessee TennCare/Medicaid Providers must have completed application forms on file before claims can be processed for payment. Please complete all documents and return to:

Department of Finance and Administration
Bureau of TennCare
Provider Enrollment Unit
310 Great Circle Road
Nashville, TN 37243 – 1700

All incomplete applications and requested documents not included will be returned to the pay-to address on your application. All documents must have original signatures.

Tennessee Providers may obtain a copy of their licensure verification from the official website of the State of Tennessee, Department of Health listed below:

http://www2.state.tn.us/health/licensure/index.htm

Note: Out-Of-State Providers must return a claim form with an attached Medicare Remittance for dually-eligible Medicare/Medicaid recipients, or a claim form only if billing for a TennCare recipient.

Completed Applications will be assigned a Tennessee Medicaid Provider Number. You will be notified in writing of your assigned Provider Number. Please file all future claims only after you receive the notification as your provider number must be stated on all claim forms. Providers who have rendered a service to a TennCare only recipient will be required to enroll with the TennCare Managed Care Organization the recipient has chosen to manage his/her healthcare. The state Medicaid ID number assigned by this office should be presented to the MCO upon enrolling. You will be assigned a billing number by the MCO for reimbursement.

Should you have any questions regarding your number assignment, please contact: 1-800-852-2683, or (615) 741-6669.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243-1700

CHECKLIST
Applied Behavioral Analyst

This check list will assist you in completing and returning the correct forms along with this document. Enrollment Packets must include the following

NPI Number _ _ _ _ _ _ _ _ _ _

NPI Collection Form _____

No. 2 Individual Application _____

Disclosure Of Ownership _____

Substitute W-9 Form _____

Copy Of License _____

Copy Of License Renewal _____
OR
Copy of Certification _____

Copy of Renewal _____

Copy of Verification of Credentialing from the BHO _____

Bureau of TennCare/Medicaid
Provider Enrollment

310 Great Circle Road
Nashville, TN 37243-1700

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
NO. 2 INDIVIDUAL APPLICATION
www.state.tn.us/tenncare/Providers/enroll.html

Complete Name: _____ **Title:** _____
(As Shown on License) **(M.D., D.D.S., etc.)**

(Check All That Apply)	_____ **Change of Ownership**
_____ **New Enrollment**	_____ **Reactivation**
_____ **MCC Medicaid No.**	_____ **Adding Practice/Satellite Location**
_____ **Medicare/Medicaid No.**	_____ **Name Change and Tax ID # Change**
Practice Location Address (No P. O. Box #)	**Pay-To Name & Address** (as shown on the I.R.S. and W-9 Form)
Street: _____	**Legal IRS Name:** _____
City: _____	**Name (cont'd)** _____
County: _____	**D/B/A Name:** _____
State: _____	**Street:** _____
Zip Code + 4: _____	**City:** _____
Telephone #: _____	**State:** _____
Fax Number: _____	**Zip Code + 4:** _____
	Telephone #: _____

Federal Tax No. (IRS No.): _____ **Social Security No. (req'd):** _____

Federal Medicare No.: _____ **State Medicaid No.:** _____ **NPI No.:** _____

Medical Specialty: _____

Taxonomy: _____, _____, _____, _____

Briefly describe the services you propose to offer to Medicaid recipients: _____

_____

_____

Board-Certified (Y/N): _____ **Board-Eligible (Y/N):** _____

Name of Board: _____ **DEA No.:** _____

Certificate No.: _____ **Date of Issuance:** _____
Month / Day / Year

Hospital-Affiliated (Y/N): _____ **Hospital-Based (Y/N):** _____

Name of Hospital: _____

Submit copies of professional licenses, and/or certifications, specifically required to operate as a health care provider.

State License No.: _____ **Date Of Issuance:** _____
Month / Day / Year

Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes ____ No ____. If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.

Please list the full name of every owner, with Social Security number and percent of ownership (required). If owned by corporation, please list corporate officers with same information. Use additional paper ,if necessary.

	Name	Title	SSN	% Ownership
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

EFFECTIVE DATE FOR OPENING/REOPENING OFFICE: _____

EFFECTIVE DATE OF CHANGE OF OWNERSHIP: _____

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any): _____

Previous Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code + 4:** _____

IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Provider's Original Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

If you belong to a group and authorize all monies due be made payable to the group, please indicate the name and provider number of said group and sign below.

_____ _____

Group Name **Medicare Group Provider No.**

Provider's Original Signature: _____ **Date:** _____

Instructions and General Information
Pertaining to Criminal Attestation and
Disclosure of Ownership and Control Interest Statement

Federal Regulations in 42 USCA 1396a(p) and 42 C.F.R. §438 require that the State plan monitor the payments of Medicaid funds to providers. The Tennessee State plan has chosen to implement this provision by use of this form which is designed to collect the information required in 42 C.F.R. §455. CMS has approved the use of this method of monitoring provider receipt of Medicaid monies. A full and accurate disclosure of ownership and financial interest is required. Direct or indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Failure to submit requested information may result in a refusal by the State agency to enter into contract with any such institution or in termination of existing contracts. This form must be submitted at the time a provider is re-accredited by the managed care organization (MCO), or whenever there is a material change in the information required by this form

GENERAL INSTRUCTIONS

If you are part of a provider group or corporation with 50 or more practitioners, who are employees of the provider, do not use this form. There is a special form you can obtain from TennCare which is designed to reduce the administrative burden of providing this information for very large practices with many practitioner employees. If you have 50 or more practitioners who are not employees of a common provider (for example doctors are self employed but share overhead and administrative staff), then each practitioner must complete the form. Please contact MCO Provider Relations for a copy of the special form.

There are two ways in which this form is being used. Firstly, individual providers need to fill out the appropriate parts of this form about themselves. Secondly, an authorized individual needs to fill out the form for groups of practitioners or disclosing entities. This authorized individual is providing information, not for the individual providers, but for the business entity i.e. the corporation or partnership, under which the providers are organized. The purpose of this form is to capture information about non-provider employees, i.e. business managers, as well as officers, members of the Board of Directors, and owners of the business entity.

THEREFORE before you fill out the form make sure you know if you are filling it out for yourself as a provider or on behalf of the business entity. Direct any questions to the MCC with which you are or will be contracted.

Please see the detailed instructions *for your particular type* of practice. For example, individuals would follow the instructions listed as "Instructions for Individuals".

If you are a **governmental entity** fill out Items I and IV. See instructions and definition for disclosing entity.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. (For example: Item II. (a) continued.)

Completely answer the questions that are applicable to your organization/business. Website and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement.

Return the original to the MCO. Please retain a copy for your files.

DETAILED INSTRUCTIONS FOR INDIVIDUALS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. **Definitions are underlined and bolded**.

Provider means an institution, facility, physician, or other health care practitioner that is licensed or otherwise authorized to provide and receive payment for any covered service furnished to TennCare enrollees. There are three categories of providers: 1) individual practitioners; 2) group of practitioners; and 3) disclosing entity.

ITEM I **(a)** Check the entity type for "Individual"

(b) Identifying Information: Specify name of your organization/business. Do not include a name of a contact person.

(c) Enter DBA name. This may be the same as (b) above.

(d) Enter address.

(e) Federal Tax Identification Number: Enter provider's nine-digit federal tax identification number.

(f) If your organization is chain affiliated you must complete Item II(a).

DO NOT FILL OUT ITEM II.

ITEM III **(a)** A provider must submit, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(b) Any significant business transactions between the provider and any subcontractor, or wholly owned supplier, during the 5-year period ending on the date of the request. 42 C.F.R. §455.105.

Subcontractor means any organization or person who provides any function or service for an individual, group of practitioners, or disclosing entity specifically related to securing or fulfilling the individual's, group of practitioner's, or disclosing entity's obligations, to TennCare. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement. 42 C.F.R. §455.101.

ITEM IV **(a)** Answer Yes or No in the boxes provided

(b) If your practice is incorporated in some fashion provide the relevant information.

(c) Answer if your practice is incorporated

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider. 42 C.F.R. §455.101.

Managing employee means an individual who exercises operational or managerial control over, or who conducts the day-to-day operation of an institution, organization, or agency. For example, general manager, administrator, or director may be considered a managing employee. The individual provider may be considered a managing employee if he/she performs these tasks. 42 C.F.R. §455.101.

DO NOT FILL OUT ITEM V .

DO NOT FILL OUT ITEM VI

SIGN & DATE FORM

Signature The signature on this form must be the written signature of the individual provider. Signature stamps are not acceptable.

DETAILED INSTRUCTIONS FOR A GROUP OF PRACTITIONERS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. **Definitions are underlined and bolded.**

The group of practitioners should submit one form for the group practice.

Authorized representative means an individual with designated authority to act on behalf of the group of practitioners. The authorized representative must be a partner, president, or secretary of the group of practitioners.

Provider means an institution, facility, physician, or other health care practitioner that is licensed or otherwise authorized to provide and receive payment for any covered service furnished to TennCare enrollees. There are three categories of providers: 1) individual practitioners; 2) group of practitioners; and 3) disclosing entity.

Group of Practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment). 42 C.F.R. §455.101.

Common location means an interconnected area or location that may consist of more than one building or office that is used for an assortment of purposes.

ITEM I **(a)** Check Group of Practitioners

(b) Identifying Information: Specify name of your organization/business. Do not include a name of a contact person.

(c) Enter DBA name. May be the same as (b) above.

(d) Enter address.

(e) Federal Tax Identification Number: Enter provider's nine-digit federal tax identification number.

(f) If your organization is chain affiliated you must complete Item II (a).

DO NOT FILL OUT ITEM II.

ITEM III **(a)** The group practice must submit, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(b) Any significant business transactions between the group practice and any subcontractor or wholly owned supplier, during the 5-year period ending on the date of the request. 42 C.F.R. §455.105.

The information in this section only applies to business transactions that the group of practitioners has entered into as a group practice.

Subcontractor means any organization or person who provides any function or service for an individual, group of practitioners, or disclosing entity specifically related to securing or fulfilling the individual's, group of practitioner's, or disclosing entity's obligations to TennCare. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement. 42 C.F.R. §455.101.

ITEM IV Answer IV (B)

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider. 42 C.F.R. §455.101.

Managing employee means an individual who exercises operational or managerial control over, or who conducts the day-to-day operation of an institution, organization, or agency. For example, general manager, administrator, or director may be considered a managing employee. A provider may be considered a managing employee if he/she carries out these administrative or managerial type functions. 42 C.F.R. §455.101.

DO NOT ANSWER ITEM V .

ITEM VI List the name, title, personal address, social security number, and percentage of interest for each member of the Board of Directors or the Board of Governors of the provider.

SIGN & DATE FORM

Signature The signature on this form must be the written signature of an authorized representative and not a signature stamp.

DETAILED INSTRUCTIONS FOR DISCLOSING ENTITY

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. **Definitions are underlined and bolded**

Disclosing entity means a Medicaid provider or a fiscal agent other than an individual practitioner or group of practitioners. 42 C.F.R. §455.101. This includes both quasi-governmental and state and local governmental entities. State and Local governmental entities need only fill out Part I and Part IV of the form. Quasi Governmental entities need to fill out all parts of the form.

ITEM I **(a)** Check Disclosing Entity.

(b) Identifying Information: Specify name of your organization/business. Do not include a name of a contact person.

(c) Enter DBA name. May be same as (b) above

(d) Enter address.

(e) Federal Tax Identification Number: Enter provider's nine-digit federal tax identification number.

(f) If your organization is chain affiliated you must complete Item II(a).

A **chain affiliate** means a freestanding health care facility that is owned or operated under lease or contract by an organization of two or more freestanding health care facilities that is under the ownership or control of a common party. Chain affiliates facilities may be public, private, charitable, or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital-based home health agencies are not considered to be chain affiliates. **List the name, address, and FEIN of the Corporation.**

ITEM II (a) **Who owns you?** List the name, title, personal address, and social security number of each office and/or individual, or the TIN for an organization, having any ownership or controlling interest, that amounts to an ownership interest of 5 percent or more in the disclosing entity (your company) submitting this Provider Contract. 42 C.F.R. §455.100; 42 C.F.R. §455.104.

Indirect ownership means an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. 42 C.F.R. §455.101.

Direct ownership interest means the possession of stock, equity in capital or any interest in the profits of the disclosing entity. 42 C.F.R. §455.101.

The amount of indirect ownership in the disclosing entity that is held by another entity is determined by multiplying the percentage of ownership interest at each level. For example, if Dr. Abby owns 10 percent of the stock in Blue Health Corporation that owns 80 percent of the stock of Medical Plus, a disclosing entity, Dr. Abby's interest equates to an 8 percent indirect ownership and must be reported. Conversely, if Dr. Bob owns 80 percent of the stock of Red Health Corporation that owns 5 percent of the stock of Medi-Pulse, a disclosing entity, Dr. Bob's interest equates to a 4 percent indirect ownership interest in Medi-Pulse and need not be reported. 42 C.F. R. §455.102.

Controlling interest means the management of a disclosing entity that has the ability or authority: to change the corporate identity; to nominate or name members of the Board of Directors or Trustees; to change the by-laws or constitution; to control the sale of any or all of the assets; to mortgage assets; to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control. 42 C.F.R. §455.101.

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if Dr. Smith owns 10 percent of a mortgage secured by 60 percent of Dr. Murray's assets, Dr. Smith's interest in Dr. Murray's assets equates to 6 percent and must be reported. Conversely, if Dr. Brad owns 40 percent of a mortgage secured by 10 percent of Dr. Jolie's assets, Dr. Brad's interest in Dr. Jolie's assets equates to 4 percent and need not be reported. 42 C.F.R. §455.102.

ITEM II (b) List those persons named in Item II (a) that are related to each other (spouse, parent, child, or sibling). 42 C.F.R. §455.104.

ITEM II (c) Who do you own? List the name, title, address, and social security number of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more. 42 C.F.R. §455.104.

Subcontractor means any organization or person who provides any function or service for an individual, group of practitioners, or disclosing entity specifically related to securing or fulfilling the individual's, group of practitioner's, or disclosing entity's obligations to TennCare. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement. 42 C.F.R. §455.101.

ITEM II (d) Who do you own? List the name, personal address, and TIN of any other disclosing entity, in which a person with an ownership or controlling interest in the disclosing entity (your company) also has an ownership or control interest of at least 5 percent or more. 42 C.F.R. §455.104.

Other disclosing entity means another entity that is required to disclose ownership and control information because of participation in any Title V, XVIII, or XX of the Act. For example, hospitals, skilled nursing facilities, home health agencies that participate in Medicare (Title XVIII) and any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges for the health related services for which it claims payment under Title V or Title XX of the Act. 42 C.F.R. §420.201.

ITEM III (a) The disclosing entity must submit, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(b) Any significant business transactions between the disclosing entity and any subcontractor, during the 5-year period ending on the date of the request. 42 C.F.R. §455.105.

ITEM IV Answer (C)

ITEM V **(a)** If there has been a change in ownership within the last year, or a change is anticipated, indicate the date in the appropriate space.

(b) If this facility is operated by a management company or leased in whole or part by another organization, list the name or the management firm and federal tax identification number or the leasing organization.

Management company means any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

(c) If you have increased your bed capacity by 10% or more or by 10 beds, whichever is greater within the last year, list the actual number of beds in the facility now and the previous number. If this doesn't apply to your type of entity check N/A.

(d) Identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include the name of the NEW Administrator, Director of Nursing, or Medical Director.

(e) List the date of any bankruptcy, if applicable.

(f) If your entity is or was a chain affiliate complete this section.

ITEM VI List the name, title, personal address, social security number, and percentage of interest for each member of the Board of Directors or the Board of Governors of the provider.

SIGN & DATE FORM

Signature The signature on this form must be the written signature of an authorized representative and not a signature stamp.

Authorized representative means an individual with designated authority to act on behalf of the individual provider.

DISCLOSURE OF OWNERSHIP
AND
CONTROL INTEREST STATEMENT

This form must be completed by an Authorized Representative, who is defined as an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity. The signature on this form must be the written signature of the authorized representative and not a signature stamp.

Item I. Identifying Information

(a) Do you practice as: ☐ individual ☐ group of practitioners at a common location ☐ a disclosing entity *Quasi-government and governmental entities see instructions.

(b) Name of Individual, Facility or Organization:

(c) DBA Name:

(d) Address:

(e) Federal Tax Identification Number (TIN) OR Social Security Number:

(f) Is this entity chain affiliated? ☐ No ☐ Yes If yes, complete Item II.

Item II. Ownership and Control Information. 42 C.F.R. §455.100; 42 C.F.R. §455.104.

(a) List the name, title, address, and SSN for each **office and/or individual** who has any ownership or controlling interest in this provider entity. The office/individual's ownership or controlling interest is an ownership interest of 5% or more of this provider entity. List the name, Tax ID (TIN), and address of any **organization, corporation, or entity** having any ownership or controlling interest in this provider entity. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity. Attach additional pages as necessary to list all officers, owners, management, and ownership entities.

Name	Title	Address	SSN/TIN	Percentage

(b) List those persons named in Item II (a) that are related to each other (spouse, parent, child, or sibling). 42 C.F.R. §455.104.

Name	Relationship	SSN

(c) List the name, title, address, and social security number of each person with an ownership or control interest in any subcontractor that this disclosing entity has direct or indirect ownership of 5% or more. 42 C.F.R. §455.104.

Name	Title	Address	SSN	Percentage

(d) List the name, address, and TIN of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more. 42 C.F.R. §455.104.

Name	Title	Address	SSN	Percentage

Item III. Business Transaction Information. 42 C.F.R. §455.105.

(a) List the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous 12-month period. 42 C.F.R. §455.105.

(b) List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. 42 C.F.R. §455.105.

Item IV. Criminal Offenses. 42 C.F.R. §455.100; 42 C.F.R. §455.106.

(A) If you are filling out this form as an individual provider, giving information about yourself, please answer the following questions:

1) (a) Have you personally been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? ☐ No ☐ Yes

(b) Has someone connected with your practice (i.e. an office manager) been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? ☐ No ☐ Yes

If you answered yes above please provide the following information for the individual with the criminal conviction.

Name	Address	Title	SSN(or TIN if an organization)

2) If you answered **Item I(a)** at the beginning of this form as an individual **AND** your practice is incorporated please list the names and addresses of the corporations Officers and Board of Directors in the spaces below.

Name	Address	Title	SSN(or TIN if an organization)

B) If you are filling this form out as an **authorized representative** of a **Group of Practitioners,** providing information about the **business entity,** please answer the following question:

1) Have you or any Director, Officer, Agent or managing employee of this Group of Providers been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? ☐ No ☐ Yes

2) If yes please list the information requested below for each person convicted of a criminal offense

Name	Address	Title	SSN (or TIN if an organization)

C)) If you are filling this form out as an **authorized representative** of a **Disclosing Entity,** providing information about the **business entity,** please answer the following question:

Have you or any other individual or organization who has ownership or a control interest in this provider been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? ☐ No ☐ Yes) If yes please list the information requested below for each person convicted of a criminal offense

Name Address Title SSN (or TIN if an organization)

_____

_____

_____

Item V. Status Changes - For Disclosing Entities Only

(a) Has there been a change in ownership or control within the last year or is a change of ownership or control anticipated within the year?

☐ No ☐ Yes

(b) Is this facility operated by a management company or leased in whole or party by another organization?

☐ No ☐ Yes

If "Yes", list date of change in operations:

(c) Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last year?

☐ No ☐ Yes ☐ N/A

If "Yes", when?

Previous No. of Beds_____ Current No. of Beds_____ Date of change:_____

(d) Has there been a change in administrator, Director of Nursing, or Medical Director within the last year?

If "Yes", please check box below and list date.

☐ Administrator ☐ Director of Nursing ☐ Medical Director Date:_____

Name of new Administrator, Director of Nursing, or Medical Director:

(e) Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year?

☐ No ☐ Yes

If "Yes", when?

(f) 1. Is this facility chain affiliated? If yes list name, address of parent corporation and EIN # ☐ No ☐ Yes

Name EIN#

Address

2. If you answered 1. above "no" was this facility ever affiliated with a chain? If yes list names address of parent corporation and EIN # ☐ No ☐ Yes

Name EIN#

Item VI. Board of Directors or Board of Governors

List the name, title, address, social security number, and percentage of interest for each of the Board of Directors or Board of Governors of this provider.

Name	**Title**	**Address**	**SSN**	**Percentage**

The State agency or secretary may refuse to enter into, renew, or terminate an agreement with this provider if it is determined that this provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. §455.106.
Authorized representative means an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity.
Name of Authorized Representative (Typed) **Title**
Written Signature **Date**

SUBSTITUTE W-9 FORM

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name: _____ Phone Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

2. Circle the most appropriate category below: (please circle only one)

1) Individual (not an actual business)
2) Joint account (two or more individuals)
3) Custodian account of a minor
4) a. Revocable savings trust (grantor is also trustee)
   b. So-called trust account that is not a legal or valid trust under state law
5) Sole proprietorship (using a social security number for the taxpayer ID)
6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
7) A valid trust, estate, or pension trust
8) Corporation
9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
10) Partnership
11) A broker or registered nominee
12) Account with the U.S. Department of Agriculture in the name of a public entity that receives agricultural program payments
13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)

3. Fill in your taxpayer identification number below: (please complete only one)

1) If you circled number 1-5 above, fill in your Social Security Number

   __ __ __ - __ __ - __ __ __ __

2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

   __ __ - __ __ __ __ __ __ __

Sign and date the form:

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: _____ Date: _____

Title (if applicable): _____

National Provider Identifier (NPI) Collection Form
(Individual/ Solo Practices)

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information
(Please make additional copies if required)

Provider Last Name	First Name	Middle	Title

Existing Medicaid ID's	SSN	EIN Number

Section 2 – NPI Information

NPI Number _____

Taxonomy Codes

Section 3 – Primary Practice Location (As Entered on NPPES)

Address _____

City	State	ZIP

Phone Number	Fax Number	Provider e-mail Address

Section 4 – Contact Information

Name of Individual Completing Form _____

Phone Number	Fax Number	Contact e-mail Address

Signature _____ **Title** _____

NPI Collection Form Surety Statement:
"I certify that the information provided on this application is complete and correct to the best of my knowledge."

Instructions
Individual/Solo Practice

Send the completed NPI Collection Form and a copy of the NPPES confirmation via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 248-4386 or (866) 456-8059
Field	**Instruction**
Section 1 – Provider General Information	
Provider Last Name	(Required) Enter the provider's last name.
First Name	(Required) Enter the provider's first name.
Middle	(Optional) Enter the provider's middle name.
Title	(Required) Enter the provider's title.
Existing Medicaid ID's	(Required) Enter all currently assigned Medicaid provider numbers.
SSN	(Required) for an individual provider. Enter the Social Security Number.
EIN Number	(Required) Enter the Employer Identification Number (could be SSN).
Section 2 – NPI Information	
National Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location line 1 address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location ZIP of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider e-mail Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact e-mail Address	(Optional) Enter the e-mail address of the individual completing this form.
Signature and Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.

National Provider Identifier (NPI) Collection Form
(Group Practices)

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information

Business Name _____

Doing Business As (Name) _____

_____ _____ _____

Medicaid ID **EIN** **NPI**

Taxonomy Codes _____ _____ _____

_____ _____ _____

Section 2 – NPI Information

(Please Complete this Section for each Individual Provider that is associated with your Group. Please Make additional copies if required)

Provider Name	Medicaid ID	NPI	SSN	Taxonomy	Taxonomy

Section 3 – Primary Practice Location (As Entered on NPPES)

Address _____

_____ _____ _____

City **State** **ZIP**

_____ _____ _____

Phone Number **Fax Number** **Provider Email Address**

Section 4 – Contact Information

Name of Individual Completing Form _____

_____ _____ _____

Phone Number **Fax Number** **Contact Email Address**

Signature _____ **Title** _____

NPI Collection Form Surety Statement:
"I certify that the information provided on this application is complete and correct to the best of my knowledge."

Instructions
Group Practices

Send the completed NPI Collection Form via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 741-0028
Field	**Instruction**
Section 1 – Provider General Information and NPI Information	
Provider Business Name	(Required) Enter the provider's name (Facilities, Agencies, Groups, Hospitals, etc.).
D/B/A Name	(Required If Applicable).
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
EIN	(Required for a business entity) Enter the Employer Identification Number.
National Provider Identification Number	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Section 2 – Group Member - NPI Information	
Provider Name	(Required) Enter the individual provider name linked to this group number.
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
NPI Individual Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Social Security Number	(Required) Enter the Individual Provider SSN.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location zip of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider Email Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact Email Address	(Optional) Enter the email address of the individual completing this form.
Signature/Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.